Standard Form 1152
(Rev. 11-91)
Title 4, GAO Manual
1152-106

DESIGNATION OF BENEFICIARY

UNPAID COMPENSATION OF
DECEASED CIVILIAN EMPLOYEE

IMPORTANT

Read instructions
on back of duplicate
before filling in this form

INFORMATION CONCERNING THE EMPLOYEE:

NAME (Last)	(First)	(Middle)	DATE OF BIRTH (Month, day, year)
			Social Security Number

DEPARTMENT OR AGENCY IN WHICH EMPLOYED

(Department or agency) (Bureau) (Division)

I, the employee named above, canceling any and all previous Designations of Beneficiary heretofore made by me, do now designate the beneficiary or beneficiaries named below to receive any **UNPAID COMPENSATION** due and payable after my death. I understand that this Designation of Beneficiary relates solely to money due as defined in 5 U.S.C. 5581, 5582, 5583, and in no way will affect the disposition of any benefit which may become payable under the Retirement or Group Life Insurance Acts applicable to my Government service. I further understand that this Designation of Beneficiary will remain in full force and effect until (1) expressly changed or revoked by me in writing, (2) I transfer to another agency, or (3) I am reemployed by the same or another department or agency of the Government.

INFORMATION CONCERNING THE BENEFICIARY OR BENEFICIARIES:

Type or print first name, middle initial, and last name of each beneficiary	Type or print address (including ZIP Code) of each beneficiary	Relationship	Share to be paid to each beneficiary

I hereby direct, unless otherwise indicated above, that, if more than one beneficiary is named, the share of any deceased beneficiary who may predecease me shall be distributed equally among the surviving beneficiaries, or entirely to the survivor. I understand that this Designation of Beneficiary shall be void if none of the designated beneficiaries is living at the time of my death.

I hereby specifically reserve the right to cancel or change any designation of beneficiary, at any time, in the manner and form prescribed by the Comptroller General of the United States, and without the knowledge or consent of the beneficiary.

(Date of execution--month, day, year) (Signature of employee)

WITNESS TO SIGNATURE:

(Signature of witness) (Number and street) (City, State, and ZIP Code)

(Signature of witness) (Number and street) (City, State, and ZIP Code)

PRINT OR TYPE NAME AND ADDRESS (INCLUDING ZIP CODE) OF EMPLOYEE

THIS SPACE RESERVED FOR RECEIVING DATA OF EMPLOYING AGENCY

(Indicate date and by whom received)

DELIVER BOTH COPIES TO THE PROPER OFFICER OF YOUR AGENCY-DUPLICATE WILL BE NOTED AND RETURNED

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